Information for Part D Sponsors on Contracting With Indian Health Care Providers

OVERVIEW

All Part D sponsors are required to offer network contracts to all Indian Health Service, Tribes or Urban Indian program (I/T/U) pharmacies operating in the sponsor's service area. These contracts must include standard terms and conditions that conform to a model contract addendum to be provided by CMS in February, 2005. The model addendum will account for differences in the operations of I/T/U pharmacies and retail pharmacies. The following provides background information on I/T/U services that will be useful to Part D sponsors as they carry out these requirements.

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing health services to descendants of federally recognized American Indians and Alaska Natives (AI/ANs). The provision of health services to AI/ANs is based on the unique government-to-government relationship between tribes and the Federal Government established by treaties, court decisions, and federal statutes. Generally, AI/ANs are not charged for medical services or pharmaceuticals provided and any co-payments and deductibles are waived for services. The IHS is the principal Federal health care provider for AI/ANs and serves as an advocate for Indian health. The mission of the IHS is to raise the health status of AI/ANs to the highest possible level.

The IHS is the primary source of health services for 55% of the estimated 2.4 million AI/ANs from more than 560 federally recognized tribes in 35 States. The IHS has a total of 88,000 Medicare beneficiaries of which approximately 30,500 are dually eligible for Medicare and Medicaid. The majority of Indian people served by IHS live on or near reservations in some of the most remote and poverty stricken areas of the country where other sources of health care are less available. Health care services are provided to AI/ANs through IHS-operated facilities, through funding agreements with Tribes or Tribal organizations pursuant to the Indian Self-Determination and Education Assistance Act, (ISDEA), and through contracts with 34 urban Indian organizations. Urban Indian health programs provide limited services to more than 150,000 Indians living in 34 cities. Five urban programs provide pharmaceutical services through in-house pharmacies. The Indian health care providers are often referred to as I/T/U programs (operated by IHS, operated by Tribes, or operated by urban programs). For many AI/ANs, the I/T/U program is the only accessible source of health care, given travel, language and cultural barriers.

HEALTH CARE FACILITIES

The IHS is organized as 12 "area offices" which are located throughout the United States. Within the 12 areas are 594 health care delivery facilities, including 48 hospitals, 232 health centers, and 314 health stations, satellite clinics, and Alaska village clinics operated by IHS and tribes. The IHS provides direct health care services at 35 hospitals

and 111 ambulatory facilities. At 13 hospitals and 435 ambulatory facilities, Tribes or Tribal organizations contract or compact under the ISDEA and have assumed operation of the delivery of health care services previously carried out by the IHS. Over one-half of the IHS resources are administered by Tribes or Tribal organizations operating health programs pursuant to the ISDEA.

PHARMACIES

There are a total of 235 pharmacies in the I/T/U system (see Attachment A for a complete list of pharmacies). Pharmacies are located in the hospitals and clinics and are operated differently than most private sector retail pharmacies. Pharmacies may have higher operating costs due to the practice model used by IHS. IHS tends to use more pharmacists and fewer technicians than the private sector pharmacies since the patient's medical record is reviewed prior to filling prescriptions and the patient receives patient counseling in private counseling room for both new and refill medications. Pharmacists at many sites run pharmacy specialty clinics following patients with specific disease states.

State	# of I/T/U Pharmacies	PDP Region #	MA PPO Region #
Alabama	1	12	10
Alaska	15	34	26
Arizona	23	28	21
California	18	32	24
Colorado	2	27	20
Connecticut	1	2	2
Idaho	3	31	23
Kansas	5	24	18
Maine	3	1	1
Michigan	7	13	11
Minnesota	7	25	19
Mississippi	1	20	16
Montana	13	25	19
North Carolina	1	8	7
North Dakota	5	25	19
Nebraska	3	25	19
New Mexico	23	26	20
Nevada	11	29	22
New York	3	3	3
Oklahoma	43	23	18
Oregon	7	30	23
South Dakota	12	25	19
Texas	2	22	17
Utah	1	31	23
Washington	12	30	23
Wisconsin	11	16	14
Wyoming	2	25	19

ACQUISITION OF PHARMACEUTICALS

The Department of Veterans Affairs (VA) provides Indian Health Service (IHS) and Tribes use of the VA Pharmaceutical Prime Vendor (PPV) for purchasing pharmaceuticals at discounted prices. By ordering through the VA PPV, IHS and Tribes are able to access Federal Supply Schedule (FSS) Contract, National Standardization Contract (NSC) and Blanket Purchase Agreement (BPA) pricing for pharmaceuticals.

In addition to accessing medications from the VA PPV, Tribes and Urban programs qualify as Federally Qualified Health Centers and after approval of the Health Resources and Services Administration Office of Pharmacy Affairs, are eligible to order medications at 340B Drug Pricing.

Because IHS acquires drugs through federal supply sources, this may impact a Medicare Part D sponsor's ability to negotiate rebates from manufacturers for these medications purchased by the I/T/U and dispensed to the plan members.

FORMULARIES

All I/T/U facilities have their own local formularies. Two IHS areas, Aberdeen and Oklahoma City, have area-wide formularies to which sites can add additional medications. The IHS also has a National Core Formulary of medications which must be available at all IHS sites.

Since most I/T/U patients see a health care provider at the I/T/U hospital or clinic and also get their medication at the same facility, the vast majority of prescribed medications are on that facility's local formulary. All facilities have non-formulary procedures in place to be able to provide patients with needed medications that are not on the local formulary.

APPROACHES TO SUCCESSFUL CONTRACTING WITH IHS, TRIBAL AND URBAN PROGRAMS

Medicare Part D Sponsors are required to offer contracts to all I/T/U pharmacies and dispensaries. Because of their unique status under Federal law, Part D Plan Sponsor will find the IHS or Tribal addendum helpful as models for an addendum to its standard pharmacy network agreement in order to contract with these pharmacies. Furthermore, some I/T/U pharmacies do not have the same point of sale capabilities typically found in commercial retail pharmacies. The addenda will allow this rather than require the I/T/U pharmacies to convert to different technologies; plans will need to work around this, including batch processing or processing paper claims routinely in the case of a few pharmacies and dispensaries. CMS will post suggested texts for these addenda on its website. All Part D Plan Sponsors are expected to model their addenda on these suggested texts and must offer them to all Indian health pharmacies in the PDP regions in

which the Sponsors will operate. The addenda to be used by each Part D Plan Sponsor must be submitted to CMS. Two addenda will be required:

- The Indian Health Service will execute a master agreement + addenda (that can vary by state) with Part D Plan Sponsors to cover all the pharmacies and dispensaries IHS operates directly.

- An Indian tribe, tribal organization or urban Indian organization which operates one/more pharmacies or dispensaries must execute an individual pharmacy network agreement + addendum with Part D Plan Sponsors.

Multi-tribal agreements. Indian tribes/tribal organizations in some areas of the country may wish to negotiate pharmacy network agreements + addendum as a group to make the process more efficient. Part D Plan Sponsors are encouraged to contact the IHS Area Health Boards to identify tribes and tribal organizations with an interest in negotiating a group agreement. *A list of IHS Area Health Boards is available at <www.nihb.org>; click on "Area Health Boards".* Each tribe or tribal organization participating in the group would execute an agreement + addendum with the Part D Plan Sponsor.

Web resources. CMS and IHS will establish web access to information on network contracting resources with I/T/Us. Information expected to be posted includes: the CMS model addenda (one for IHS; one for tribes, tribal organizations and urban Indian organizations); contact personnel at IHS Area Health Boards; contact personnel at individual tribal and urban programs; and, on a voluntary basis if plans so desire, network pharmacy agreements/ addenda developed by Part D Plan Sponsors. Sponsors interested in this opportunity should provide a copy of their materials to the following for posting on the website:

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Principal Pharmacy Consultant
Indian Health Service
801 Thompson Ave., Room 319
Rockville, MD 20852
Phone: 301-443-1190
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REIMBURSEMENT FOR INDIAN HEALTH PHARMACIES

IHS patients do not pay for health services received at I/T/U facilities. Pharmaceuticals provided to patients by I/T/Us or paid for by contract health services will satisfy the plan deductible under the Part D benefit. However, pharmaceutical costs paid by I/T/U pharmacies will not count toward a beneficiary's "true" out-of-pocket limit, after which the beneficiary receives catastrophic coverage. (In contrast, drug costs paid by CMS for individuals eligible for the low-income subsidy under Part D, including the cost of covered drugs obtained at I/T/U pharmacies, will count toward the true out-of-pocket limit.) IHS patients who do not qualify for the low income subsidy under Part D are not

expected to be able to reach the catastrophic limit. [*Note: the low-income subsidy is not only available to full-benefit dually eligible individuals, but also other low-income individuals.*] This would limit the Sponsor's annual claims payment liability for each AI/AN enrollee to $1500.

CMS's model addenda for network pharmacy agreements with IHS, tribe/tribal organization and urban Indian organization pharmacies provide that a Part D Plan Sponsor pay the pharmacy's claims at rates that are reasonable and appropriate to cover their costs. In the Medicare-approved Prescription Drug Discount Card Program, the two sponsors who received CMS' approval to administer the transitional assistance credit at these pharmacies used the applicable States' Medicaid reimbursement rates (AWP-X%, plus dispensing fee). While Part D sponsors are not required to contract for these rates, Attachment B is provided as a reference for the types of rates under which I/T/U pharmacies presently contract.